

**Description of Dental Benefits Provided Under  
Medicaid and the Children's Health Insurance Program (CHIP)  
State: Washington  
Updated: 7/17/09**

The following information will identify the general categories of services available in your State. Please note that while a service may be available, you must consult with your dental provider to ensure that the service is medically necessary for your specific condition. For more specific information, please contact your State program.

State Contact: **Medical Assistance Customer Service Center**

Telephone Number: **1-800-562-3022**

E-mail Address: <http://hrsa.dshs.wa.gov/contact/MailForm.aspx>

**Medicaid Program**

- Under the Medicaid State Plan dental benefits are provided to eligible individuals under the age of 21 in compliance with the requirements of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

State Program Name: **Age 20 and under dental program; Access to Baby and Child Dentistry (ABCD)**

**CHIP Program**

- CHIP Medicaid Expansion Program ONLY, i.e., offering complete oral health services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

State Program Name: same

- CHIP Stand-Alone/Separate Program ONLY  
State Program Name: **Age 20 and under dental program; Access to Baby and Child Dentistry (ABCD)**

Dental Services Provided through State-defined benefit package

Benchmark Equivalent Program: **Medicaid**

Name of :

Optional Supplemental Dental Coverage for CHIP eligible children with private or group insurance

- CHIP Medicaid Expansion and Stand-Alone Program (dental services are as described above)  
State Program Name:

**If providing dental benefits other than as defined by EPSDT, States must complete the following:**

**CHIP Stand-Alone Program Dental Benefits**

NOTE: Please identify any limits or other criteria using terms commonly recognized by individuals without extensive oral health terminology knowledge rather than using technical dental terminology. For example, use molar rather than posterior, or front versus anterior.

**Schedule of Services**

- State EPSDT definition  
OR

- Nationally Recognized Standard

Name and Description: **Early Periodic Screening, Diagnosis, and Treatment**

Recommended Age for First Oral Health Examination: **Before first birthday**

**Preventive Services:**

- Cleanings  
a. Recommended frequency: **Every six months**  
b. Exceptions: **None**

- Fluoride treatments
  - a. Ages: **through age 20**
  - b. Recommended frequency: **age 0-6 3x year; age 7-18 2x year; age 18-20 1x year**
  - c. Also provided by physicians:  **through age 5**
  - d. Also provided by hygienists:  **through age 20**
  - e. Exceptions:
- Sealants
  - a. Ages: **through age 18**
  - b. Recommended frequency: **1x every three years**
  - c. Exceptions: **case-by-case**
- Oral hygiene instruction
  - a. Ages: **through age 8 and only in non dental clinics (e.g. schools)**
  - b. Recommended frequency: **2x per year**
- Space Maintainers
  - a. Limits **only for missing primary (baby) molars (back teeth)**
  - b. Prior approval required: Y/N **no**

#### Diagnostic Services:

- Dental Examinations by Dentists
  - a. Recommended age of first visit: **prior to age one**
  - b. Recommended frequency: **2x year**
  - c. Limits: **2x year**
- Dental Screens and Other Services by Hygienists
  - a. Recommended frequency:
  - b. Limits: **2x year**
- X-Rays
  - a. Limits: **Limited by type of x-ray must meet prevailing standard of care**

#### Treatment Services:

- Fillings
  1. Silver amalgam: 
    - a. Limits: **every two years for same restoration (filling)**
  2. Tooth colored composite: 
    - a. Limits: **every two years for same restoration (filling)**
- Crowns/Tooth Caps
  1. Stainless steel crowns: 
    - a. Limits: **1x every three years**
    - b. Prior approval required:
  2. Metal (only) crowns 
    - a. Limits:
    - b. Prior approval required:
  3. Metal/Porcelain crowns: 
    - a. Limits: **anterior (front) teeth only**
    - b. Prior approval required:
  4. Porcelain (only): 
    - a. Limits: **anterior (front) teeth only**
    - b. Prior approval required:
- Root Canals (endodontics)
  1. Root canals on baby teeth (Pulpotomies): 
    - a. Limits: **1 per tooth**
    - b. Prior approval required:
  2. Root canals on permanent teeth: 
    - a. Limits: **none**
    - b. Prior approval required:
- Gum (periodontal) Therapy

- a. Limits: **age 13-20**
  - b. Prior approval required:
- Dentures
  - 1. Partial dentures: 
    - a. Prior approval required:
  - 2. Complete dentures: 
    - a. Prior approval required:
- Retainers (orthodontic)
  - a. Limits: **age limitation – must meet department criteria**
- Bridges
  - a. Limits:
  - b. Prior approval required:
- Implants:
  - a. Criteria:
- Oral Surgery
  - 1. Simple extractions: 
    - a. Limits:
    - b. Prior approval required:
  - 2. Surgical extractions: 
    - a. Limits:
    - b. Prior approval required:
  - 3. Care of abscesses: 
    - a. Limits:
    - b. Prior approval required:
  - 4. Cleft palate treatment: 
    - a. Limits:
    - b. Prior approval required:
  - 5. Cancer treatment: 
    - b. Limits:
    - c. Prior approval required:
  - 6. Treatment of Fractures: 
    - a. Limits:
    - b. Prior approval required:
  - 7. Biopsies: 
    - a. Limits:
    - b. Prior approval required:
- Treatment of Jaw Joint (TMJ)
  - a. Criteria:
  - b. Prior approval required:
- Braces (Orthodontia)
  - a. Criteria: **cleft-palate or severe malocclusions (bites) as determined by the department**
  - b. Prior approval required:
  - c. Payment if eligibility lost:
- Emergency Room Services
  - a. Identify services:
  - b. Criteria:
- In-patient Hospital Services
  - a. Criteria: **prior approval if non-emergency**
  - b. Prior approval required:
- Special Anesthesia
  - a. Criteria: **General Anesthesia through age 8**
  - b. Prior approval required:  **for age 9 and older**

#### Excluded Services

1. Identify services: **posterior (back tooth) crowns, gum surgery, implants, bridges**